DEPARTMENT POLICY

Medicaid

The Michigan Department of Health and Human Services/Medical Services Administration (MSA) is responsible for the following medical programs in Michigan:

- Medicaid.
- Maternity Outpatient Medical Services (MOMS).
- Breast and Cervical Cancer Prevention and Treatment Program (BCCPTP).

The Michigan Department of Health and Human Services (MDHHS) administers Medicaid under the supervision of MSA. MSA administers the BCCPTP and MOMS programs.

MSA has established a no-wrong-door policy for Medicaid to expand where a person may submit an application for medical assistance.

MSA RESPONSIBILITY

Maternity Outpatient Services

Information about Maternity Outpatient Services (MOMS) is in BEM 657.

- Local office MDHHS staff do not determine eligibility for MOMS.
- Local office MDHHS staff determine Medicaid ESO for pregnant women and enter the correct codes for pregnancy and citizenship, thereby allowing MOMS eligibility.
- MOMS is **not** Medicaid.
- MOMS is **not** on Bridges.

Breast and Cervical Cancer Prevention and Treatment Program

MSA determines eligibility for this MA category. Policy and procedures are in BEM 173.

Policy Exceptions

MSA is responsible for responding to requests for **policy exceptions** for Medicaid. Complete instructions are in BEM 100. Send policy exceptions to:

Michigan Department of Health and Human Services/Medical Services Administration
Bureau of Medicaid Policy and Health System Innovations
Eligibility Policy Section
PO Box 30479
Lansing, MI 48909

MDHHS LOCAL OFFICE RESPONSIBILITY

MDHHS determines eligibility for:

- Medicaid.

  Exception: MSA determines eligibility for BEM 173, Breast and Cervical Cancer Prevention and Treatment Program.

- RAP Medical.

HMO (LC 07) Becomes L/H Client

MSA and MDHHS share responsibility when a recipient in an HMO (Level of Care (LC) code 07) enters a long-term care (LTC) facility.

The provider contacts the Health Maintenance Organization (HMO) to request that the client be disenrolled from the HMO. The HMO submits the request for disenrollment to MSA.

The Quality Improvement Section, Medical Services Administration, reviews the documentation and decides whether to approve the HMO's request for disenrollment.

Do **not** request a change to LC code 07 when a client enters LTC. The HMO is responsible for requesting the disenrollment.

> ***Exception:*** A recipient might be enrolled in managed care after admission to LTC. In such cases, contact MSA at (517) 241-8759 to request removal of LC code 07.

MSA is responsible for:

- Ending LC code 07 on Bridges.
- Adding LC 02 or 08 and the Provider ID on Bridges. The authorization begin date for LC 02 or 08 is the day after the LC 07 end date.
- Forwarding a copy of the DCH-1185, Request to Disenroll from Health Plan to Nursing Facility, to the local DHS.

  Note: All DCH-1185s for recipients in Wayne County will be forwarded to the medical district. That office is responsible for obtaining the case record from the appropriate district office.

If notified that a recipient in managed care has entered LTC before there is notice of the HMO disenrollment, you may begin actions necessary to determine continued eligibility (request verifications). However, not all case actions can be completed until the DCH-1185 is received from MSA.

DHHS is responsible for:

- Determining continuing eligibility. Computing the post-eligibility patient-pay amount.
- Entering the post-eligibility patient-pay amounts after MSA has entered LC 02 or 08 in Bridges.

Use standard negative action procedures to begin the patient-pay amount; see BEM 547.

Newborns

MSA AUTHORIZATIONS in BEM 145, Newborn explains when the Medical Services Administration will authorize MA for a newborn.

LOCAL HEALTH DEPARTMENTS AND MDHHS

Local health departments may participate in outreach and application assistance.

Application assistance means helping clients apply for and obtain verifications for Medicaid. Each local health department chooses whether or not it will participate.

Local health department Responsibilities

For applications submitted through the participating local health department, the local health department is responsible for:

- Ensuring that the application is signed and that all items are completed. Items that do **not** apply are to be marked N/A.
- Obtaining all information needed to make an eligibility determination and supplying copies of all necessary documentation and verification.
- Doing a preliminary income budget to determine if the application should be submitted for a Medicaid determination.
- Attaching documentation of the client's noncooperation with obtaining verifications to the application.

Missing Verification

An application received from a participating local health department should have all the information and verification necessary to determine Medicaid eligibility. If all of the necessary information/verification does **not** accompany the application:

- Contact the local health department and request that the local health department obtain the missing information or verification. Use the DHS-3503, Verification Checklist, or other mutually agreeable written means, to notify the local health department of the missing information or verification.

Do **not** delay a determination of eligibility because an application does **not** specify a family's choice of a health or dental plan.

- Allow the local health department at least 10 days to provide the information or verification.
- Contact the local health department if the requested information is **not** received by the due date. Extend the time limit if there has been a delay in getting the information or verification (BAM 130). Do **not** deny the application as long as the local health department is working to obtain the information or verification.
- If the local health department says that verification **cannot** be obtained despite a reasonable effort, use the best available information. See Obtaining Verification in BAM 130 for details and exceptions.
- If the local health department indicates that the client has **not** cooperated in efforts to obtain verification, review the local health department's documentation relating to the refusal (copies of correspondence, record of telephone contacts). Determine if the client has refused to cooperate. Deny the application, if appropriate. If denial is **not** appropriate (client was not informed of what was needed or client was not given sufficient time), ask the local health department to request the verification again.

MDHHS Application Processing

When an application is submitted through a participating local health department:

- Register the application if it contains at least the applicant's name, the applicant's birth date, the applicant's address, and the applicant's/authorized representative's signature; see BAM 105, Right to Apply. The application date is the date the application is received at MDHHS with the minimum information.
- Determine eligibility for Medicaid.
- Notify the client of the eligibility decision.

Informing local health departments and Confidentiality

Confidentiality is **not** violated when information is provided to local health departments regarding applications and eligibility or ineligibility.

Provide the following information if participating local health departments want to know the disposition of an application:

- Whether a person has been approved for Medicaid.
- Whether coverage is limited to emergency services.
- If denied, the reason for each person's denial.
- Each beneficiary's ID number.
- The begin date of MA coverage, including retro MA coverage.

Changes and Renewals

MDHHS is responsible for:

- Reviewing continued eligibility when changes are reported, including obtaining any necessary verification.

  Exception: Medicaid Under 19 and MIChild eligibility continues until renewal unless the child reaches age19, moves out of state, becomes ineligible due to Institutional Status, dies,. or (MIChild only) is enrolled in other comprehensive health insurance.

- Processing renewals.

EXCEPTIONS UNIT

Certain Bridges transactions must be processed through the Exceptions Unit in MSA. The MA exceptions unit telephone numbers are:

- 1-800-292-9570 (requires security card) - This is a voice-activated enhanced call process with 6 menu items.

- 517-241-8759 - This is a voice-mail line to use to request removal of Level of Care (LC) codes 07 or 88. A series of questions prompts callers to leave the information necessary to remove the LC code. A response will state when the LC code

will be removed. If the LC code cannot be removed or other information is needed, the worker will be contacted.

Call 517-241-8759 directly or 1-800-292-9570 and press 3 to remove these LC codes.

Referrals to MSA Reimbursement Unit

Notify MSA of the potential need for reimbursement of paid medical expenses. Send reimbursement information to:

Michigan Department of Health and Human Services
Medical Services Administration
Att: Venetta Watt
Eligibility Quality Assurance Section/Reimbursement
400 S. Pine St., 5th floor
Lansing, MI 48913
MSA Estate Recovery Unit

Recoveries for Medicaid claims correctly paid are as follows:

- For individuals who received medical assistance at age 55 or older, recovery is made from the individual's estate for all services covered by the Michigan Medicaid program with dates of service on or after July 1, 2010, except Medicaid cost sharing. To be subject to estate recovery, a person over 55 must have begun receiving long-term care services after September 30, 2007. If a beneficiary over the age of 55 began receiving long-term care services prior to September 30, 2007 and there was a break in coverage and a new eligibility period began any time after September 30, 2007, the Medicaid recipient will be deemed to have begun receiving long-term care after September 30, 2007 and therefore be subject to recovery.
- Recovery will only be pursued if it is cost-effective to do so as determined by the department at its sole discretion.

Limitations on Recoveries

The state complies with the requirements of section 1917(b)(2) of the Social Security Act: Recovery of medical assistance will be made only after the death of the individual's surviving spouse, and

only when the individual has no surviving child who is either under age 21, blind, or disabled.

Undue Hardship

Recovery may be waived if a person inheriting property from the estate can prove that recovery would result in an undue hardship. An application for an undue hardship must be requested by the applicant and returned with proper documentation in order for a hardship waiver to be considered. In order to qualify for a hardship exemption, an applicant must file the application with the department not later than 60 days from the date the department sends the Notice of Intent to the personal representative or estate contact. An undue hardship exemption is granted to the applicant only and not the estate generally.

Undue hardship waivers are temporary. Submitted applications will be reviewed by the department or its designee, and the department shall make a written determination on such application.

An undue hardship may exist when one or more of the following are true:

- The estate subject to recovery is the sole-income producing asset of the survivors (where such income is limited), such as a family farm or business.
- The estate subject to recovery is a home of modest value, see definition in this item.
- The state's recovery of decedent's estate would cause a surviving heir to become or remain eligible for Medicaid.

When considering whether to grant an undue hardship, the department shall apply a means test to all applicants to ensure that waivers are not granted in a way that is contrary to the intent of the estate recovery program under federal law.

An applicant for an undue hardship waiver will satisfy the means test only if both of the following are true:

- Total household income of the applicant is less than 200 percent of the poverty level.
- Total household resources of the applicant do not exceed $10,000.

Definitions:

- **Survivor:** An heir who does not predecease the deceased beneficiary under the provisions of MCL 700.2104 or according to the terms of the decedent's will.
- **Home of Modest Value:** A home that is valued at 50 percent or less of the average price of homes in the county where the home is located as of the date of the Medicaid beneficiary's death.
- **Value of Medicaid recipient's home:** The State Equalized Value (SEV) of a Medicaid recipient's home from the year the Medicaid recipient died is used to determine whether that home is a home of modest value. The SEV will be double to find the value of the home.
- **Average Price**: The average price of homes in the county shall be determined from the Equalized Valuation Totals Summary report (L-4023) published by the State Tax Commission. The average price shall be calculated by dividing the total True Cash Value of Residential Real Property in the county by the total Number of Parcels.
- **Resources:** All income, as defined in BEM 500 series, and assets, as defined in BEM 400 an applicant has.
- **Long-Term Care Services**: Means services, including but not limited to, nursing facility services, hospice, home and community based services, adult home help, and home health.

Divestments

When a divestment is discovered, it will be determined if the state was aware of the transfer and whether the transfer was or would have been allowed. If necessary MSA will refer the case to the Office of the Attorney General to have the property put back in the estate.

MSA will not pursue a divestment when any of the following are true:

- The transfer of assets was disclosed as part of the Medicaid eligibility determination process and notwithstanding such transfer, the applicant was determined to be Medicaid eligible.

- The transfer of assets was not disclosed as part of the Medicaid eligibility determination process, but the department determines that if it had been disclosed the applicant would still have been determined to be Medicaid eligible.

- The transfer was disclosed as part of the Medicaid eligibly determination process, and a divestment penalty was assessed, which at the time of the decedent's death was exhausted.

MSA will refer a divestment to the Michigan Department of Health and Human Services Office of Inspector General, or MSA will seek additional recovery from the estate when either of the following are true:

- The transfer of assets was disclosed as part of the Medicaid eligibility determination process, a divestment penalty period was assessed and the assessed penalty period had not been exhausted at the time of the beneficiary's death. MSA will only seek the value of the outstanding penalty period that was assessed under these circumstances.

- The transfer of assets was not disclosed as part of the Medicaid eligibility determination process, and the department determines that if it had been disclosed the applicant would not have been determined to be Medicaid eligible.

Appeals

The Hardship Waiver applicant has the right to contest the department decision of whether an undue hardship exists. The applicant may request a hearing within 60 days of the notice of case action on the application. The request for a hearing must be in writing and will be conducted under the provisions of BAM 600, Hearings.

HEALTHY MICHIGAN PLAN COST-SHARING

All individuals who are eligible for the Healthy Michigan Plan (HMP) and enrolled in a Medicaid health plan will pay most cost-sharing through the MI Health Account. Cost-sharing includes co-pays, and for some beneficiaries, contributions. Point of service co-pays may be required for a limited number of services that are carved out of the health plans, such as certain drugs. HMP co-pay information, including amounts, can be found at the Michigan Department of

Health and Human Services (MDHHS) website for Assistance Programs/Health Care Coverage, or by calling the Beneficiary Help Line at 1-800-642-3195.

Individuals eligible for HMP who are not enrolled in a health plan are only responsible for co-pays when applicable, and will pay those co-pays at the point of service.

Contributions

HMP beneficiaries with incomes above 100 percent of the Federal Poverty Level (FPL) may be charged monthly contributions for their health care coverage. Contribution amounts vary based on income and family size and will not exceed 2 percent of household income. Some individuals may be exempt from contributions.

Exemptions, and any other changes to the contribution amount because of changes in income or other demographic information will be processed by the MI Health Account vendor prospectively.

When a beneficiary is no longer eligible for coverage under HMP, he may be entitled to the remainder of any unused contributions in the MI Health Account. These funds may only be used to purchase private health insurance coverage.

Cost-Sharing Reductions for HMP Beneficiaries

Beneficiaries may earn cost-sharing reductions to co-pays and contributions owed through the MI Health Account.

Offset of State Tax Refunds and Lottery Winnings

Beneficiaries who fail to meet HMP cost-sharing obligations may be subject to offsets of their state tax refunds and lottery winnings. Beneficiaries who meet the criteria established for offsets will be notified of the potential for an offset and of his rights to a review of the referral of his unpaid cost-sharing amounts.

Cost-Sharing Limits

The limit is based on income and applies to most types of health care coverage cost-sharing including HMP.

Beneficiaries in the same household cannot be charged more than 5 percent of the family's income each calendar quarter for cost-sharing. Updates to the cost-sharing limit occur prospectively as income and other changes are received. MDHHS monitors the cost-sharing limit and costs as they are incurred and processes changes each quarter. Beneficiaries are not required to keep track of these costs.